

Continuing Education for the Specialist

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■ *Specialists are having many difficulties defining and developing more effective methods in the area of continuing medical education. Present unorganized multifaceted mechanisms are too little utilized by the majority to be acceptable. A cooperative effort by parent specialty organizations, accredited hospital staffs and the State Board of Medical Examiners could explore the possibility of establishing standards by which a qualitative and quantitative review of the level of performance of physicians could be done. The initiative must be exercised by these groups to forestall governmental intervention.*

IN THIS ERA, there is general uneasiness with regard to medical education in general, particularly continuing education in special fields of practice. Much is being written about the needs in this area and innumerable ideas have been propounded to solve the problem, but there is no coordinated effort being made by a practical pilot study to prove the effectiveness of any plan, at least not in this geographical area.

Many of us depend upon crude methods of keeping ourselves up to date in knowledge of drugs, diagnostic modalities, technical changes, medical and surgical management and preventive procedures. The gap between town and gown, the reluctance of practitioners to take time to improve competence, and the severe lack of time leaves us struggling in a sea of confusion. Although I utilize my own specialty of obstetrics and gynecology to explore the problems relating to continuing education and suggested solutions, it is apparent that the discussion is applicable to all specialties.

Continuing medical education for obstetricians-gynecologists concerns at least three groups of

physicians, the practicing obstetrician-gynecologist, the teaching obstetrician-gynecologist and the family practice obstetrician-gynecologist. As in other disciplines, the explosion of scientific knowledge in health care in our field has been as phenomenal as the population explosion and as difficult to cope with. Keeping "refreshed" while overly busy providing health care is becoming very arduous and much needs to be done to organize methods which will be practical and usable.

Present Methods

At present we depend upon many "self helps" to keep us up to date—hospital conferences, periodic seminars and assemblies, medical association scientific sessions, national and regional specialty colleges and postgraduate programs.

The "self helps" include the use of the voluminous supply of periodicals in our own specialty as well as closely allied disciplines. Each year we are afforded approximately 1,900 pages of current opinion in our green journal, *Obstetrics and Gynecology*; 3,600 pages in the gray journal, *American Journal of Obstetrics and Gynecology*; and innumerable pages in various abstract publications such as the *Survey* which has some international

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flavor. The British, the International Federation and other foreign journals are readily available to most of us. The more highly specialized material in fertility, endocrinology, cancer and other subjects provides information to a more limited group.

California Medicine and the Journal of the American Medical Association are more diversified but do appear on our desks regularly with another 5,500 pages of yearly effort by authors in varied fields.

Reading material only has value when it is properly read—a fact which I am afraid lessens its effect as a refresher. With such a tremendous supply available, many depend upon summary scanning, which is inadequate.

Another “self help” modality of continuing education is the perennial supply of Audio-Digest tapes provided for us by a subsidiary of the California Medical Association. Selected subjects by authoritative discussants find wide use by generalists and by colleagues in our own specialty.

Hospital conferences in community institutions frequently are limited to the required cursory review of the accumulative clinical material of the preceding month supplemented by periodic guest speakers, usually oriented to general practitioners or to house officers. Teaching institutions provide more sophisticated presentations at grand rounds and didactic conferences are of great value in keeping staff members up-to-date. Many community hospitals have annual symposia with visiting professors offering presentations more generally oriented and thus of only occasional benefit to our section.

Periodic seminars and assemblies such as regional meetings sponsored by the state medical associations and the universities attract interest widely over our state and others, but are often too diversified. The Assembly and Forum of Southern California is an intensified effort to bring international authorities with current opinions to a significant proportion of us each year.

Obstetric-gynecologic sections of state and national associations have annual and semi-annual programs of limited interest which are not well attended and could not be a dependable sole refresher.

The most rewarding experience in our continuing education is the regional and national meetings of the American College of Obstetricians and Gynecologists and the American College of Surgeons. Each has formal postgraduate programs,

discussions on investigative work, roundtables, conferences and many variable attractions including televised live clinics and surgical demonstrations, plus numerous exhibits.

Postgraduate efforts of our medical schools continually offer in-training to those who wish to brush up or become enlightened in special techniques and make studies in depth of new knowledge.

All of these mechanisms are being used by a relatively small proportion of obstetrician-gynecologists and there is no assurance that those most in need are being exposed effectively to them. It is the individual's choice and his own conscience that determines the degree of his participation.

Why, then, should we concern ourselves with continuing medical education since it is available to us to choose and use as we will?

Demands for Change

The interest has increased for many reasons and there is a growing demand for control and accurate evaluation by the medical profession, government and other segments of society. Planners for health care in and out of organized medicine view the aging doctor of medicine as one who persists in the practice and teaching beyond his time of astuteness and physical ability. It has been long felt that some restrictions should be applied in this area. We know that chronologic age alone is a very fallacious guideline to follow and as yet proper mechanisms have not been developed which would determine the senior physician's ability.

The continuing use of outmoded practice indicated by routine subtotal hysterectomy, the combined abdominal with vaginal approach to prolapse, Watkin's interposition operations, frequent use of classic cesarean section, and homeopathic antibacterial therapy for septic conditions identifies the hermit pelvic surgeon who has not improved his knowledge in this field since World War II. These patterns often develop early in one's career and are even sometimes exemplified by the young specialist who finishes his training, completes his military obligations, quickly becomes busy and isolated from exposure to the rapid advances and seldom returns to the mainstream.

The present system of assuring continuing medical education seems inadequate when we view the rapid advances in our field. There is much need for an orderly plan which would guarantee not only exposure of all of us to such current knowl-

edge, but would evaluate the effectiveness of the system.

Organized medicine through our county, state and national associations is constantly studying, developing and applying various techniques, theories and attractions which would involve every physician in some refresher experience. The American College of Obstetricians and Gynecologists has pioneered the system of continuing education for its own members and has worked with the American Academy of General Practice to improve the standards of practice in its field. The leaders have done this because of the founding principles which make the College responsible for our continuing education; and other organizations have offered cooperation to help carry out the task. In fact, the College is carrying out the demands of the members of our specialty to establish and maintain standards of continuing postgraduate education in this field.

All obstetrical-gynecological societies in California and this region of the United States, including our own San Francisco society, the Pacific Coast society and others, base their reason for existence on the premise of improving standards of practice and so require their members to remain current in all aspects of knowledge in our specialty. There is an increasing hunger for new information by the majority in our discipline.

National and state "Medicare" laws have indicated a demand for better health care of the senior citizens and the medically indigent throughout the country. Those who give substandard care are being identified by review committees in our communities and they are being removed as purveyors of medical service to these people. Regardless of agreements and contractual arrangements, it will remain a truism that he who pays the fiddler will call the tune, and government will make competence surveys mandatory.

The Board of Medical Examiners, working with the deans of medical schools, insurance carriers and the California Medical Association, has recognized a growing need for evaluation of the grass-roots standards of practice among physicians and is studying the methods by which each individual doctor of medicine can be screened as to his ability to continue practice with or without restrictions.

Although we all abhor governmental control, whether state or national, we do enthusiastically accept the necessity in other areas such as control over safety of airline and other public carriers or

even the high standards required when we seek our license to practice. Periodic recheck on the latter is what the Board of Medical Examiners will demand if a better solution is not forthcoming.

Trial lawyers and the courts are bringing more and more pressure upon the physician witness or defendant to show his grasp of new medical ideas and prevalent practice. Thus, the malpractice and forensic considerations also make continuing education imperative.

Many observers believe alternative methods by the state can be formulated in a more practical manner than examinations, undercover reports or other distasteful methods.

Suggested Mechanisms

If appropriate committees of all accredited hospitals were required to make reports on staff physicians periodically to the Board of Medical Examiners, a realistic level of performance of the majority of our practitioners would evolve. Other methods would be needed for physicians practicing in small hospitals and outlying areas.

The American Board of Obstetrics and Gynecology, which is under the control and jurisdiction of the American Medical Association, has never undertaken reevaluation of its diplomates once they are certified. This is true of the American College of Obstetricians and Gynecologists and the American College of Surgeons. Potentially, all three offer many possibilities of including certification review within their purview.

The American Academy of General Practice was organized on the premise of establishing and maintaining a system of requiring continuing education for all its members. A specific quantity of documented quality postgraduate work over a stated period is required in order to maintain membership in the organization. This of course does not interfere with the licensed right of physicians to practice, but experience has shown that few physicians choose to lose their membership in the Academy for failure to do the required postgraduate study. It is not, then inconceivable that the American Colleges and/or the American Boards might arrive at a common standard of requirements for postgraduate education and insist that their members offer periodic evidence of fulfilling their obligation. This mechanism was recently submitted by John B. Dillon, M.D., of UCLA. He suggested that evidence of compliance be appended to one's license and that it be available to patients

as well as to surveyors. He pointed out that re-examination by the Board of Medical Examiners would be unreasonable, impractical and perhaps of minimal factual value. Reexamination by the Colleges and others would similarly be of questionable effectiveness.

The new public law concerning heart disease, stroke and cancer makes possible cooperative arrangements improving the care of persons with these diseases. This development concerns our specialty (in at least one facet) and deserves some consideration. Mr. Paul Ward, executive director of the California Regional Medical Program, has described efforts to stimulate local participation and determination of local needs by the men and women most directly concerned with meeting them. For planning purposes these locally determined needs are to be aided by administrative staffs of the eight medical schools in California. These efforts will, no doubt, bring about evaluation of various levels of professional ability in the communities served throughout the California region, which includes the Reno-Sparks-Carson City and Las Vegas areas of Nevada.

In the past, medical schools and teaching hospitals have been similar to the Board of Medical Examiners and other certifying organizations in that they give the blessing of competence to the graduate and rarely have the opportunity to keep track of the physician they have produced, or to attract his attention to continuing education. There is no functioning method, at this time, of assuring society that obstetricians-gynecologists and practitioners in other branches of medicine and surgery are continually maintaining their professional competence.

It seems obvious that if we as a profession do not develop a working mechanism and activate it promptly, then the state will surely do so in an

arbitrary manner. Our College has the means and motivation to do this and it is incumbent upon the Fellows to urge a trial plan in our state by working with the Board of Medical Examiners to obtain acceptability.

Conclusion

It is apparent that current methodologies of continuing education for specialists are undefined, poorly organized and inadequately utilized for present and future effectiveness. Guidelines should be developed in each specialty, at the level of a non-arrogated parent organization, which would outline the requirements and minimal standards of those in that field. It would behoove the practitioner to be continually informed of new knowledge and techniques in his own chosen way, and his acumen would be measured by quantitative and qualitative credit earned in a specific period of time.

Concurrently, periodic reports from departmental committees of all accredited hospitals utilized by the physician, similar to the reports now required by the American Board of Obstetrics and Gynecology for applicants, should be obtained to complete the evaluation. These two basic mechanisms could be activated every fifth year and serve a useful purpose. I feel sure the Board of Medical Examiners would cooperate. Even physicians who are reluctant to stand the test of competence would more readily accept a method such as this than governmental decree.

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